STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011788	A. BUILDING: _____ B. WING _____	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKIANA MEDICAL CENTER LLC	4601 MEDICAL PLAZA WAY CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 011788 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - Hospital full survey August 20-22, 2012 Date of ISDH off site review - - October 04, 2013 Reviewer/Surveyor Nancy Otten RN, PHNS Based on review of the August 20-22, 2012 HFAP Accreditation Survey Report, it has been determined that Kentuckiana Medical Center meets the requirements for Hospital Licensure in Indiana.	S 000		